1985

Rose Mitchell v. Hillhaven Corporation Voluntary Participant Benefit Trust : Brief of Respondent

Utah Supreme Court

Robert J. Debry; H. Brian Davis; Robert J. Debry and Associates; Attorneys for Plaintiff/Appellant.
Terrie T. McIntosh; Fabian and Clendenin; John H. Pierce; Foster, Pepper and Riviera; Attorneys for Defendant/Respondent.

1985 20665

IN THE SUPREME COURT OF THE STATE OF UTAH

ROSE MITCHELL, Plaintiff and Appellant, v. HILLHAVEN CORPORATION VOLUNTARY PARTICIPANT BENEFIT TRUST, Defendant and Respondent.	)	Case No. 20665

BRIEF OF RESPONDENT

Appeal from the Summary Judgment of the Third Judicial District Court of Salt Lake County, State of Utah
The Honorable Scott Daniels

Terrie T. McIntosh
FABIAN & CLENDENIN,
a Professional Corporation
Twelfth Floor
215 South State Street
Salt Lake City, Utah 84111
Telephone: (801) 531-8900

John H. Pierce
FOSTER, PEPPER & RIVIERA
1111 Third Avenue Building
Seattle, Washington 98101
Telephone: (206) 447-4400

Attorneys for Defendant-Respondent

Robert J. DeBry
H. Brian Davis
ROBERT J. DEBRY & ASSOCIATES
Attorneys for Plaintiff-Appellant
965 East 4800 South, Suite 2
Salt Lake City, Utah 84117
Telephone: (801) 262-8915

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases — Page

Rules

STATEMENT OF THE ISSUES

1. Whether there were any legal issues or genuine issues of material fact that should have prevented the district court from granting defendant's motion for summary judgment.

2. Whether the district court properly denied a motion for leave to amend brought after the court had ruled on the cross-motions for summary judgment.

STATEMENT OF THE CASE

Plaintiff and appellant Rose Mitchell's ("Mitchell") statement of the facts in her opening brief is generally accurate as far as it goes but is incomplete in critical respects. Mitchell's most serious omission is her failure to explain the procedural history of the case, which defendant and respondent Hillhaven Corporation Voluntary Participant Benefit Trust ("Hillhaven") believes is dispositive and renders irrelevant the arguments contained in Mitchell's brief.

The case involves a dispute about whether Mitchell is obliged to return approximately $3,300 in medical benefits paid by Hillhaven to Mitchell on the condition that it be repaid in the event Mitchell received a settlement or obtained a judgment compensating her for injuries caused by a third party.

1. Procedural History

The facts, outlined below, are straightforward and are not in dispute. The procedural posture of the case is less clear, thanks to Mitchell's inappropriate tactics and failure to adhere to the requirements of the Utah Rules of Civil Procedure.

Mitchell's complaint asks for an interpretation of the language of a medical plan that Mitchell contends relieves her of the burden of reimbursing Hillhaven (R at 2-4), while Hillhaven's counterclaim asks for judgment based on an assignment executed by Mitchell and signed by Mr. DeBry, her attorney (R at 10-13).

No answer to the counterclaim was filed and no affirmative defenses were raised. Instead, the parties agreed to and did file cross-motions for summary judgment, each on the parties' respective theories of the case. Hillhaven submitted an affidavit as well, authenticating the assignment upon which its counterclaim rested (R at 53-60). For eight months the memoranda stayed on file before the motions were called up for hearing. Mitchell did not respond to Hillhaven's motion and did not file any affidavits in support of her motion or in opposition to Hillhaven's. No defenses to the assignment were ever raised. There were no allegations of fraud, coercion or mistake -- the usual defenses in avoidance of a written document -- in the complaint or her written memorandum.

It was only after Hillhaven's counsel pointed out in oral argument on the cross-motions for summary judgment that no allegations legally sufficient to defeat the assignment had ever been made that Mitchell's counsel orally offered the suggestion that there <u>might</u> be fraud or coercion.

After the court ruled, granting Hillhaven's motion for summary judgment and denying Mitchell's motion, Hillhaven's counsel prepared an order and judgment. As required by the

Supplementary Rules of Practice for the Third Judicial District, Rule 4(b),[1] a copy was submitted to Mitchell's counsel before filing (R at 80). Before the judgment was signed, Mitchell's counsel prepared a motion to amend the complaint and to withhold entry of judgment (R at 73-75). In the proposed amended complaint, Mitchell sought to raise allegations of fraud that might raise sufficient factual questions to defeat summary judgment (R at 65-71).

After a hearing on March 1, 1985 the court denied Mitchell's motion for leave to amend the complaint (R at 77, 81). On March 19, 1985 the judgment was signed and entered (R at 78-80), and the order denying Mitchell's motion to amend her complaint was signed on April 8, 1985 (R at 81-82). On April 19, 1985, after hearing Mitchell's objections to the order denying the motion to amend, the court modified the order to read that the motion to amend was denied because no triable issue of fact had been raised (R at 82).

2. Factual Background

Hillhaven Corporation employees, such as Mitchell, receive as part of their employee benefits the right to

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[1] The rule provides as follows:

> Copies of the proposed order, judgment or decree in civil and domestic cases shall be served on opposing counsel before being presented to the court for signature unless approved as to form by opposing counsel, or the court otherwise orders. Notice of objections thereto shall be filed with the court and served on opposing counsel no later than five (5) days after service of said proposed order, judgment or decree.

participate in the Hillhaven Corporation Voluntary Participant Benefit Trust, which provides reimbursement for medical and hospital expenses. The medical benefits are provided pursuant to the Trust Major Medical Plan ("Plan"). The Plan is administered by Northwestern National Life Insurance Company, but Hillhaven itself is not an insurance company (R at 29-30).

In the Plan booklet, the section entitled "Coordination of Benefits" contains a subsection entitled "Third Party Liability," the intent of which is to avoid the payment of duplicate benefits to any Plan participant.[2/] While Hillhaven will pay if there is no other recovery in the case of illness or accidental injury "caused by an act or an omission to act by another person. . . ," there are two conditions precedent to the Plan's paying otherwise eligible expenses. These conditions precedent are (1) the submission of the expenses to any other insurance or health plan that has incurred "third party liability" to the Plan member and (2) execution of a written agreement to reimburse the Plan if damages are collected. When the medical expenses paid by the Plan are subsequently also paid by a third party, the Plan seeks reimbursement of the portion it paid on the basis of the assignment it required to be executed.

In summary, then, those Plan participants who are injured or become ill and are not otherwise compensated are paid

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[2/] A copy of the relevant plan provision is attached to the brief as Appendix A.

by the Plan. Those who have received compensation once, however, are not allowed to receive double compensation for the same injury.

In the case at bar, Mitchell was in the process of trying to collect compensation for her medical expenses and injury when she sought payment for hospital and doctor bills from the Plan. As a condition of her receiving benefits, Hillhaven required her to execute an assignment to Hillhaven of "any monies recovered by court judgement, insurance settlement, or otherwise, on account of, or in connection with" the injuries she received from the fall in the home of Mr. and Mrs. Wilson (R at 30-31). The assignment was for no more than amounts paid by the Plan on account of the injuries sustained in the fall.[3/]

The assignment, signed by both Mitchell and her attorney, Robert DeBry, also contained an acknowledgment that the assignment was required by the Plan as a condition precedent to payment of benefits.

After receiving payment from the Plan, Mitchell claimed she should not have been required to sign the assignment. She did not, however, object at the time, refuse to sign the assignment and bring suit to force the Plan to make the payment she now claims she was entitled to. Instead, Mitchell got her Plan

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[3/] A copy of the assignment executed by Mitchell is attached to the brief as Appendix B. As Mitchell correctly points out, when she requested the assistance of the Plan in paying her hospital and medical expenses, she was sent a copy of the Plan provision that Hillhaven contends covers her case and an assignment form.

benefits, got her settlement and then refused to reimburse the Plan, as she had agreed.[4/]

SUMMARY OF THE ARGUMENT

1. Because Mitchell did not respond to Hillhaven's motion for summary judgment and, in particular, because she did not file opposing affidavits, no factual issues were raised to support any defenses to the assignment of benefits executed by Mitchell and signed by her attorney.

2. The undisputed facts are legally insufficient to defeat the assignment, since no claims for fraud, failure of consideration, duress or bad faith are stated by or can be inferred from the facts that are in the record.

ARGUMENT

There are before the Court only two questions on appeal, namely (1) whether there were factual issues or incorrect legal rulings that should have precluded summary judgment and (2) whether Mitchell's motion to amend was properly denied. No other issues were raised in or implicated by the proceedings below.

[4/] Correspondence attached to the affidavit of Dan Holets shows Mitchell's inquiry about whether the Plan would waive its claims under the assignment so she could accept a settlement offer of $12,500. (R at 56-57) Ultimately she negotiated a settlement for and received $16,000 (R at 31), an increase of $3,500 or approximately the amount of the double recovery that Mitchell has refused to repay to Hillhaven.

I. THE DISTRICT COURT WAS REQUIRED TO FIND THERE WERE NO FACTUAL ISSUES BECAUSE OF MITCHELL'S FAILURE TO FILE OPPOSING AFFIDAVITS.

In the district court Hillhaven based its motion for summary judgment on the assignment and Mitchell based her motion on a claim that the assignment was not required by the Plan. Mitchell failed to respond to Hillhaven's motion for summary judgment and failed to file any opposing affidavits, although she was on notice, and had been for months, that Hillhaven rested its claims on the assignment she executed. She thus failed in her own motion and in her response to raise any factual issues that could preclude summary judgment. Accordingly, at the time the court heard and ruled on the cross-motions for summary judgment, it had before it no defenses to the assignment itself. It was only in the proposed amended complaint that allegtions of fraud, bad faith and failure of consideration appeared (R at 65-70).

Moreover, even if the court had permitted Mitchell to amend the complaint, so that she had raised additional issues in a pleading, this would not be sufficient to raise a dispute about the material facts.[5/] Rule 56(e), Utah Rules of Civil Procedure, addresses this possibility:

[5/] There is an additional objection to Mitchell's efforts to raise factual issues after the court's oral ruling. The local rules of the Third District Court require counsel to serve proposed orders for which they cannot obtain opposing counsel's consent five days before they can be signed by the court. Accordingly, if issues not properly raised in connection with summary judgment motions can simply be introduced

(Footnote continued on next page)

> When a motion for summary judgment is made and supported as provided in this Rule, an adverse party may not rest upon the mere allegations or denials of his pleading, but his response, by affidavits or as otherwise provided in this Rule, must set forth specific facts showing that there is a genuine issue for trial. If he does not so respond, summary judgment, if appropriate, shall be entered against him.

This Court has strictly interpreted the language of the rule and held that the opponent of a motion for summary judgment must file affidavits raising factual issues "or risk the trial court's conclusion that there are no factual issues." Franklin Financial v. New Empire Development Corp., 659 P.2d 1040, 1044 (Utah 1983); Cowen & Co. v. Atlas Stock Transfer Co., 695 P.2d 109 (Utah 1984); Olwell v. Clark, 658 P.2d 585 (Utah 1982); Lockhart Co. v. Anderson, 646 P.2d 678 (Utah 1978).

Based on Rule 56 and the cases interpreting it, the attempt to amend the complaint was legally insufficient to raise any factual issues, since pleadings are not a substitute for sworn affidavits. Hence, the district court's denial of the motion for leave to amend was not only perfectly proper but the court could not have done otherwise. Having ruled on the matters before it by way of summary judgment and there being nothing further in the record that could raise a factual dispute, the district court had

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(Footnote continued from previous page)

by way of a motion to amend after the court has ruled and counsel discovers the judge's thinking, then the utility of such motions will be greatly diminished, since counsel for the losing party is assured of at least five days within which to prepare a motion to amend.

before it no basis for reopening a matter that had already been decided.

For the same reasons, Mitchell is not entitled to raise these same issues on appeal to this Court.

> For a question to be considered on appeal, the record must clearly show that it was timely presented to the trial court in a manner sufficient to obtain a ruling thereon; . . .

Franklin Financial, 659 P.2d at 1045. Mitchell failed to adhere to this requirement by offering affidavits in the district court proceedings and should not now be permitted to avoid the consequences of that failure by arguing the issues of fraud, consideration and coercion as though they are now properly at issue in this appeal.

II. MITCHELL'S DEFENSES TO THE ASSIGNMENT ARE LEGALLY INSUFFICIENT TO DEFEAT IT.

Mitchell has gone well beyond the record to create the illusion of unfairness on the part of Hillhaven. Had she followed the procedures set out in Rule 56, of course, then Hillhaven would have had an opportunity to respond in the district court. Even without the benefit of facts Hillhaven could have introduced below, however, it is apparent that none of Mitchell's claims warrants serious consideration.

A. Claims for Fraud Will Not Stand When There Is No Misrepresentation.

Mitchell complains that she was fraudulently induced to execute the assignment because Hillhaven misrepresented that the assignment was required under the Plan provisions. Since Mitchell concedes that she received a copy of the pertinent portions of the

Plan, however, there is no basis for her claim that she was misled as to its requirements.

In Utah, in order to establish a claim of fraud, the plaintiff must show:

> (1) [t]hat a representation was made; (2) concerning a presently existing material fact; (3) which was false; (4) which the representor either (a) knew to be false, or (b) made recklessly, knowing that he had insufficient knowledge upon which to base such representation; (5) for the purpose of inducing the other party to act upon it; (6) that the other party, acting reasonably and in ignorance of its falsity; (7) did in fact rely upon it; (8) and was thereby induced to act; (9) to his injury and damage.

Pace v. Parrish, 122 Utah 141, 247 P.2d 273, 274-75 (1952). Since Mitchell has the burden of showing each of these nine elements and since she cannot, as a matter of law, establish elements (2) or (6), her claim is unsustainable.

1. Hillhaven's Position was Fully Disclosed Before Mitchell Executed the Assignment.

As to element (6), that Mitchell acted in ignorance of the supposed misrepresentation's falsity, her own admission that she received the Plan provision relied on by Hillhaven in requiring the execution of the assignment shows she knew or should have known of the thing of which she complains. Mikkelson v. Quail Valley Realty, 641 P.2d 124, 126 (Utah 1982) (plaintiff not entitled to complain about square footage of house when corrct figure was disclosed in appraisal report); Cheever v. Schramm, 577 P.2d 951, 954 (Utah 1978) (plaintiffs did not reasonably rely on representations as to income of company when they had

opportunities to inspect and did inspect business records, which showed actual expenses of company).

2. Representations About the Legal Effects of Documents are Not Actionable.

Furthermore, Mitchell cannot establish a second necessary element of fraud, namely that there was a misrepresentation of a presently existing material fact. The only claimed misrepresentation was that the Plan required the execution of the assignment, yet this is a statement as to the legal effect of a document and hence is not actionable. Berkeley Bank for Cooperatives v. Meibos, 607 P.2d 798, 805 (Utah 1980); Ackerman v. Bramwell Investment Co., 80 Utah 52, 12 P.2d 623 (1932).

In short, Mitchell and her attorney had access to the document upon which Hillhaven based the assignment and could have determined for themselves then what they now claim, after Mitchell received double compensation for her injuries. Her claim to have been deceived by what was fully disclosed simply does not withstand scrutiny and can only be construed as an attempt to divert attention from Mitchell's refusal to keep her agreement with Hillhaven.

B. There is No Failure or Lack of Consideration.

1. The Assignment was Permitted Under Plan Provisions

In order to make a claim for lack of consideration Mitchell conveniently proposes to read out of existence substantial portions of the relevant Plan provisions upon which

Hillhaven relied in requiring Mitchell to execute the assignment. As a general policy, Hillhaven attempts to control costs for medical care for beneficiaries of the Plan by, inter alia, reimbursing members for medical expenses only after all other possible sources of payments are exhausted.[6/] To implement this general policy beneficiaries are required to agree to reimburse Hillhaven in the event of a recovery to the extent of the benefits provided (R at 45).

The applicable Plan provision thus requires a participant injured by another to submit eligible expenses "to any other insurance plan or health plan" which has incurred liability, and specifically includes as an example no fault insurance plans. Mitchell imagines that Hillhaven must have meant by this language other first-party insurance carried by the Plan participant, because no fault insurance can be first-party insurance and because of Plan language referring to written denials and the appeal of such denials. (App. Br. at 7)

Mitchell's argument is thus roughly as follows: the Plan means something other than what it says; on my interpretation, the

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[6/] The preface of the Plan booklet from which Mitchell quotes also states:

> By coodinating benefits with other group plans, we want you to secure the maximum reimbursement for eligible expenses from your combined coverages. We feel sure that you do not wish to receive more than 100% reimbursement when any additional payments would come from the Trust Fund deposits of your fellow employees and the corporation.

Plan was not entitled to require the assignment; therefore the assignment was invalid.

In fact, contrary to Mitchell's assertions, the language of the Plan is consistent with the Court's understanding of the term "third-party" insurance in Beck v. Farmers Insurance Exchange, 701 P.2d 795, 978 n.2 (Utah 1985):[7/]

> We use the term "first-party" to refer to an insurance agreement where the insurer agrees to pay claims submitted to it by the insured for losses suffered by the insured. . . . In contrast, a "third-party" situation is one where the insurer contracts to defend the insured against claims made by third parties against the insured and to pay any resulting liability, up to the specified dollar limit.

In the Beck case, the plaintiff was injured in a hit and run accident in a stolen car. He submitted a claim to the car owner's insurance company but liability was denied. Presumably, had the process been available, Beck could have "appealed" within the company or, had the case appeared meritorious, he could have sued the insurer. Id. at 796. Having received no compensation from the third-party insurer, however, Beck turned to his own first party insurance company to make his claim. In other words, in the Beck case the procedure envisaged by the Hillhaven Plan provision was followed, at least in part, when a claim was initially submitted to a third-party insurer.

In the case at bar, the homeowner who bore some responsibility for Mitchell's fall had third-party insurance, as

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[7/] This case on appeal was also handled by Robert J. DeBry, representing the plaintiff.

defined by Beck, and a claim was submitted by Mitchell's attorney. Unlike Beck, Mitchell negotiated and ultimately received a settlement from the third-party insurer, a settlement that took account of and included the amount that Mitchell knew she would have to repay the Plan. The first-party insurer, Hillhaven, was thus relieved of any obligation to pay as well under the terms of Mitchell's contract.[8/]

2. There was Separate Consideration for the Assignment

Mitchell claims there was no consideration for the assignment, viewed as an independent basis for her obligation to Hillhaven.[9/] Even if the Court accepts Mitchell's theory of the case to the extent of holding that Hillhaven was not entitled to require the assignment under the Plan language, the undisputed facts are that Mitchell executed the assignment and received the payment she sought.

Thus, the case can be conceptually analyzed as involving a separate agreement. In exchange for Hillhaven's agreement to pay immediately a claim it believed it could have waited to pay

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[8/] If Mitchell had submitted a claim to State Farm Insurance Co., the company carrying the homeowners policy which ultimately paid for Mitchell's injuries, and if the claim had been denied and the denial had been appealed under the express terms of the provision the Plan would have paid. None of this happened, however, since State Farm paid Mitchell.

[9/] If there were no dispute or if the Court finds that the assignment was properly required pursuant to the Plan, of course, consideration would not be an issue at all. It becomes an issue only because the district court based its ruling on the assignment alone.

and possibly never paid, Mitchell executed an assignment to repay Hillhaven in the event she obtained compensation. There is sufficient consideration under the circumstances. See, e.g., Thayer v. Brady, 28 Wash.2d 767, 184 P.2d 50 (1947).

As an alternative basis for decision, the doctrine of promissory estoppel also applies. Mitchell promised, by executing the assignment, to return any overpayment of her medical expenses to Hillhaven, and on the strength of that assignment Hillhaven gave Mitchell, in effect, an interest-free loan to pay her medical expenses until the issue of her settlement was resolved. In addition, Hillhaven, by helping Mitchell with immediate medical expenses, took the risk that Mitchell could not or would not reimburse the plan, as she promised, thereby suffering a detriment. Mitchell knew, of course, that it was only by executing the assignment that she could induce the action she sought. Accordingly, she should now be estopped from repudiating her agreement. See, e.g., Sugarhouse Finance Co. v. Anderson, 610 P.2d 1369, 1373 (Utah 1980).

C. Mitchell's Apparent Attempt to Plead Duress or Bad Faith Cannot be Sustained.

Mitchell's hyperbolic effort to analogize her situation to an injured person releasing a right to sue should not be confused with a legally recognized defense to the assignment she executed. Hillhaven has been unable to determine, given the

complete lack of citation to authority, exactly what point Mitchell is attempting to make in her brief.

1. There was No Duress or Coercion

It is possible that Mitchell is attempting to argue duress or coercion, one of the classic defenses to a contractual obligation, but there is simply no attempt to set out the elements of such a defense. See, e.g., Heglar Ranch, Inc. v. Stillman, 619 P.2d 1390, 1391 (Utah 1980) (to defeat a contract on basis of duress a party must show that the other party committed a wrongful act which put other party in fear so as to compel him to act against his will). Furthermore, the Court has previously recognized that being in difficult circumstances, such as needing to pay doctor bills, is not legally sufficient to constitute duress. Horgan v. Industrial Design Corp., 657 P.2d 751 (Utah 1982) (emotional distress and need for money to pay for surgery for handicapped son not sufficient to show coercion and invalidate a release).

Although conceivably a person in a "half lit hospital room" (Appellant's Brief at 10) might be subject to overreaching, Mitchell was not such a person and her attempts to evoke the Court's sympathy by speculaton as to her financial need go far beyond the record. Moreover, Mitchell was at all times assisted by counsel, who handled both her claim against the homeowners and her request for assistance from Hillhaven and who presumably advised her as to her legal rights and obligations when she executed the assignment that also bears his signature.

2. Mitchell Fails to State a Claim for Bad Faith

Alternatively, Mitchell may believe a mere assertion of bad faith, however groundless, may somehow state a claim. In light of the Court's ruling in Beck v. Farmers Insurance Exchange, 701 P.2d 795 (Utah 1985), however, such a belief is unjustified. In Beck, the Court confined claims of bad faith in the settlement of insurance claims to actions based on breach of contract rather than in tort, and in particular to breaches of an implied covenant of good faith and fair dealing.

There is not any evidence in this case that Hillhaven breached such an implied covenant. As outlined in Beck, the duties of a first-party insurer are these:

> [W]e conclude . . . that the insurer will diligently investigate the facts to enable it to determine whether a claim is valid, will fairly evaluate the claim, and will thereafter act promptly and reasonably in rejecting or settling the claim.

Id. at 801. Since Hillhaven fully disclosed its position to Mitchell and quickly responded to her request by paying her medical bills, there is nothing Mitchell can point to that would constitute a breach of any obligation under the contract. Contrary to Mitchell's insinuations, the assignment was clearly limited to any amounts received by Mitchell on account of the injuries caused by her fall up to but not in excess of any payment by the Plan. See Appellant's Brief at 9, where the quotation omits the limiting language of the assignment.

If there has been bad faith at all, it can only be inferred from Mitchell's promise to repay the Plan, immediately

followed by her adamant refusal to do so. Short of Hillhaven's giving up a bona fide claim sustained by the district court, it is difficult to imagine how Hillhaven's actions could have been more circumspect.

In short, even if the Court were to rule that Mitchell had preserved her complaints, an examination of her claims lays bare their lack of substance. Even on Mitchell's fanciful view of the facts that goes well beyond the record, there is simply no basis for defeating the assignment of benefits.

CONCLUSION

For the foregoing reasons the district court's ruling granting Hillhaven's motion for summary judgment should be affirmed.

DATED this 1st day of November, 1985.

John H. Pierce
FOSTER, PEPPER & RIVIERA

FABIAN & CLENDENIN,
a Professional Corporation

By Terrie T. McIntosh
Terrie T. McIntosh

CERTIFICATE OF SERVICE

I hereby certify that this 1st day of November, 1985, I caused to be mailed by first class mail, postage prepaid, four true and correct copies of the foregoing Brief of Respondent to:

Robert J. DeBry
H. Brian Davis
Robert J. DeBry & Associates
Attorneys for Plaintiff-Appellant
965 East 4800 South
Suite 2
Salt Lake City, Utah 84117

Susan J. McAtee

Pre-Existing Conditions Limitation

You and/or your covered dependents will not be eligible for any benefits for eligible expenses relating to a Pre-Existing Condition A Pre-Existing Condition means either

A Pre-Existing Condition means either

- Conditions or symptoms which existed within one (1) year prior to the effective date of your coverage and for which a prudent person would ordinarily seek treatment or
- any conditions or symptoms for which medical advice, care, or treatment was recommended or received within one (1) year prior to the effective date of your coverage

However, following any of the periods described below, eligible medical expenses arising after the expiration of these periods will be eligible for benefits payment according to the plan provisions

- A period of six (6) consecutive months which ends any time after the effective date of the individual's coverage in which the covered person has not received any prescribed drugs or medicines, medical care, treatment, or advice of such illness or injury
- You have been covered under this plan for twelve (12) consecutive months

COORDINATION OF BENEFITS

How do other group type plans affect benefits?

The Plan will coordinate benefits if you or your covered dependent are eligible to receive benefits or services for medical/dental care or treatment which are provided by

- Any group, blanket, or franchise insurance plan or any other covering individual or members as a group
- Any group hospital service prepayment plan, group medical service prepayment plan, group practice, or other prepayment coverage
- Government plans, including Medicare as explained in the following section, or statute

One plan is primary One plan is secondary The primary plan pays benefits in accordance with its terms The secondary plan pays a reduced amount which, when added to the benefits paid by the primary plan, equal 100% of eligible expenses

Which plan is primary?

A plan that does not coordinate with other plans is always the primary plan If both plans coordinate, the primary plan is determined in the following order

1) The plan which covers you or your covered dependent as an employee, rather than as a dependent, is primary
2) If a child is a covered dependent under both plans,

- the plan of the person who is financially responsible for a dependent is primary
- when the parents are separated or divorced, the plan of the parent with custody is primary,
- when the parents are divorced and the parent with custody of the child has remarried, the plan of the parent with custody is primary and the plan of the stepparent is secondary
- If neither 1 or 2 applies, the plan which has covered you or your covered dependent the longest is primary

Norwithstanding any provision of the immediately preceding sentences to the contrary, payment of benefits by the plan, as a secondary plan will be contingent upon submission ot written proof by you or your covered dependent to the Insurance Department of payment or denial ot payment, including any denial atter appealing, by the primary plan of benefits for eligible expenses incurred

If you or your covered dependent are also eligible for Medicare, the Plan will adjust benefits tor Medicare before co-ordinating benefits

How does Medicare affect benefits?

If you are an entitled individual, benefits payable under the Summary of Health and Life Benefits will be reduced first, by the benefits payable by Medicare for the same eligible expenses and second, by benefits payable by the Other Plan, provided such Other Plan is designated a "primary" plan

Third Party Liability

In the event you or your dependent incur eligible expenses for treatment of Illness or Accidental Injury caused by an act or an omission to act by another person, your right and the right of your dependent to receive benefits in payment of such eligible expenses is contingent upon submission of the eligible expenses for payment to any other insurance plan or health plan, including any No-Fault Automobile Insurance, or Personal Injury Protection, which has incurred third party liability to you or your dependent as a result of such person's act or omission to act (the "Third Party Plan") To the extent the Third Party Plan denies payment of the eligible expenses in writing and states its reasons for such denial and you have appealed such denial in strict accordance with the terms of the Third Party Plan, the Plan shall pay benefits to you or your dependent for such eligible expenses as provided by the terms of the Plan

In the event the Medical Plan provides benefits in accordance with the above paragraph, you or someone legally qualified and authorized to act on your behalf must agree in writing to

Reimburse the Plan to the extent of benefits provided under this Plan whenever damages are collected by legal action, settlement, or otherwise

For valuable consideration, the undersigned hereby assign(s) to pay over to the Hillhaven Corporation Voluntary Participant Benefit Trust, 1015 Center Street, Caller Service 2264, Tacoma, Wa 98401-2264, any monies recovered by court judgement, insurance settlement, or otherwise, on account of, or in connection with injuries sustained by Rose Maria Mitchell, 218 Edith Avenue, Apt. 2, Salt Lake City, Ut 84111, arising out of that certain injury on January 21, 1983, at 224 Pioneer Street, Midvale, Ut, up to an amount equal to, but not in excess of the payments made or to be made by said Plan on account of medical, hospital, surgical and other expenses in connection woth or arising out of said injuries.

I expressly authorize and direct my attorney to make payments of such monies to the Hillhaven Corporation Voluntary Participant Benefit Trust upon receipt of advice from said Plan as to the amount of such expenses.

It is expressly understood that the rules and regulations of The Hillhaven Corporation Voluntary Participant Benefit Trust require thae making and effectuation of the Assignment as a condition precedent to the payment of any benefits with respect to the injury above.

Date:_____, 19___.

ACCEPTED AND APPROVED

Date: 5 - 12, 1983. Rose Maria Mitchell
Employee Signature

Attorney's Signature

APPENDIX B